

SETTLEMENT AGREEMENT BETWEEN
THE MISSOURI BOARD OF REGISTRATION FOR THE HEALING ARTS
AND
JERRY LASTER, M.D.

Jerry L. Laster, M.D., ("Laster") and the Missouri State Board of Registration for the Healing Arts ("the Board") (collectively "the parties") enter into this Settlement Agreement ("Agreement") for the purpose of resolving the question of whether Laster's license as a physician and surgeon, license number R1G49 ("license"), will be subject to discipline. Laster and the Board jointly stipulate and agree that a final disposition of this matter may be effectuated as described below pursuant to § 536.060, RSMo.

Laster acknowledges that he understands the various rights and privileges afforded by law, including the right to a hearing of the charges against him, the right to appear and be represented by legal counsel, the right to have all charges against him proven upon the record by competent and substantial evidence, the right to cross-examine any witnesses appearing the hearing, the right to present evidence on his own behalf, the right to a decision based upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against him, and subsequently, the right to a disciplinary hearing before the Board at which time evidence may be presented in mitigation of discipline. Having been advised of these rights provided him by operation of law, Laster knowingly and voluntarily waives each and every one of these rights and freely enters into this Agreement.

Laster acknowledges that he has been informed of his right to consult legal counsel in this matter.

The parties stipulate and agree that the disciplinary order agreed to by the Board and Laster in Part II herein is based only on the Agreement set out in Part I herein. Laster understands that the Board may take further disciplinary action against Laster based on facts or conduct not specifically mentioned in this document that are not now known to the Board but may be discovered hereafter.

Laster understands and agrees that the Board will maintain this Agreement as an open record of the Board as required by Chapters 334, 610, 620, and 621, RSMo, as amended.

Laster acknowledges that he has received a copy of the investigative report and other documents relied upon by the Board in determining that there was cause for discipline, along with citations to law and/or regulations the Board believes were violated.

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Based upon the foregoing, the Board and Laster herein jointly stipulate and agree to the following:

JOINT PROPOSED FINDINGS OF FACT

1. The Board is an agency of the state of Missouri created and established pursuant to ' 334.120, RSMo 2000, for the purpose of executing and enforcing the provisions of Chapter 334, RSMo.

2. Laster is licensed by the Board as a physician and surgeon, license number R1G49. Laster's license was originally issued on July 28, 1986. Laster's license is and was current and active at all relevant times herein.

3. At the time of the events described herein, Licensee practiced as a physician and surgeon in Nevada, Missouri.

Count I – Patient W.B

4. The parties incorporate paragraphs 1 through 3 by reference as though fully set forth herein.

5. In September, 2003, patient W.B. was referred to Laster with diagnoses of inflammation of the gall bladder, gallstones, and sarcoidosis. W.B. also suffered from thrombocytopenia incident to his sarcoidosis.

6. W.B. was an eighty (80) year old male.

7. Laster scheduled W.B. for laproscopic surgery to remove W.B.'s gall bladder on September 26, 2003 at Nevada Regional Medical Center in Nevada, Missouri (ANevada Regional@).

8. During the September 26, 2003 surgery, Laster was unable to perform the procedure with the laparoscope due to bleeding and adhesions in W.B.'s abdomen. W.B. then performed the removal of W.B.'s gall bladder by means of an open procedure.

9. During the September 26, 2003 surgery, Laster left a surgical clip attached to W.B.'s common bile duct.

10. Following surgery, W.B. was severely jaundiced. W.B. was still jaundiced one week after surgery when W.B. visited Laster to have W.B.'s stitches removed. Laster, and other physicians, involved in W.B.'s care believed the jaundice was caused by W.B.'s sarcoidosis.

11. W.B.'s condition progressively deteriorated following the surgery. By the time the clip was discovered, W.B. had become too weak to tolerate further surgery.

12. W.B. died on November 21, 2003. The immediate cause of death was fungal infection from a catheter. The surgical clip's transection of W.B.'s common bile duct and the subsequent delay in the diagnosis of the common bile duct transection contributed to W.B.'s death.

Count II – Patient D.I.

13. The parties incorporate paragraphs 1 through 12 by reference as though fully set forth herein.

14. In December, 2004, Laster treated patient D.I., a 37-year-old female with a diagnosis of chronic pancreatitis and recurrent pancreatic pseudocyst.

15. On December 7, 2004, Laster performed exploratory laparotomy with distal pancreatectomy, resection of pancreatic pseudocyst, splenectomy and gastronomy tube insertion on patient D.I. at Nevada Regional.

16. During the December 7, 2004 procedure, Laster nicked D.I.'s vena cava, a major blood vessel in D.I.'s abdomen.

17. Although Laster responded appropriately to the cut to D.I.'s vena cava, D.I. suffered substantial blood loss which set in motion a chain of events that led to the disseminated intravascular coagulopathy (DIC) and death on December 7, 2004.

18. Laster exercised poor judgment in undertaking a high-risk surgery at Nevada Regional Medical Center and failing to take down D.I.'s pseudocyst through a window in D.I.'s stomach.

Count III – Discipline

19. The parties incorporate paragraphs 1 through 18 by reference as though fully set forth herein.

20. On or about December 9, 2004, following the death of patient D.I., the Executive Committee at Nevada Regional instituted a peer review of Laster=s care of D.I..

21. An outside review was conducted by Confidential Peer Review, Ltd. (“CPR”).

22. After reviewing the chart, CPR concluded that Laster=s preoperative assessment was questionable. In addition, CPR concluded that Laster did not adequately prepare the surgical team and support staff, and that Laster rendered inadequate postoperative care. CPR also noted that Laster did not adequately described the location of the pseudocyst in relation to other anatomical structures.

23. Based upon CPR=s report and observations regarding Laster=s care of patients M.S. and M.C., the Executive Committee at Nevada Regional placed Laster on Precautionary Summary Suspension.

24. After conducting a hearing, the Executive Committee at Nevada Regional issued a letter of reprimand to Laster on February 21, 2005.

25. On February 22, 2005, Laster resigned from the Board of Directors and from the medical staff of Nevada Regional.

JOINT PROPOSED CONCLUSIONS OF LAW

26. Cause exists for Petitioner to take disciplinary action against Licensee=s license pursuant to ' 334.100.2(4)(g), RSMo 2000, which states in pertinent part:

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person=s certificate of registration or authority, permit or license for any one or any combination of the following causes:

....

(g) Final disciplinary action by any professional medical or osteopathic association of society or licensed hospital or medical staff of such hospital in this or any other state or territory, whether agreed to voluntarily or not, and including, but not limited to, any removal, suspension, limitation, or restriction of the person=s license or staff or hospital privileges, failure to renew such privileges or license for cause, or other final disciplinary action, if the action was in any way related to unprofessional conduct, professional incompetence, malpractice or any other violation of any provision of this chapter.

....

(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the

performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, **Repeated negligence** means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant=s or licensee=s profession;

27. The final disciplinary action at Nevada Regional as described in Count III falls within the intendments of § 334.100.2(4)(g), RSMo.

28. The conduct described in Counts I and II constitutes conduct which was harmful to a patient and “repeated negligence” under § 334.100.2(5), RSMo.

29. Therefore, cause exists for the Board to take disciplinary action against Laster’s license under § 334.100.2(4)(g) and (5), RSMo.

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JOINT AGREED ORDER

Based on the forgoing, the parties mutually agree and stipulate that the following shall constitute the order entered by the Board in this matter under the authority of § 621.110, RSMo. This agreement will be effective immediately on the date entered and signed by the Board’s executive director.

Effective the date the Board enters this Agreement:

30. Laster’s medical license (number R1G49) lapsed in 2007 when Laster voluntarily elected not to renew his license after relocating his medical practice out of state. The medical license, license number R1G49, of Laster, is now hereby **VOLUNTARILY SURRENDERED** in lieu of disciplinary action.

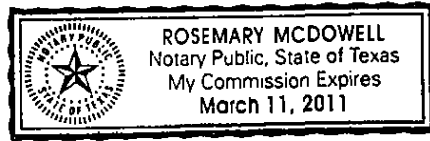
31. Laster understands that this Agreement will be reported to the National Practitioner's Data Bank, the Health Integrity and Protection Data Bank, and the Federation of State Medical Boards as an action in lieu of discipline.

32. Within ten (10) days of the effective date of this Agreement, Laster shall return all indicia of Missouri medical licensure to the Board, including, but not limited to, hi wall-hanging license and pocket card.

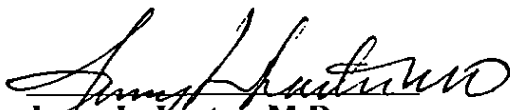
33. Laster hereby waives and releases the Board, its members and any of its employees, agents, or attorneys, including any former Board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees costs and expenses, and compensation, including, but not limited to any claim for attorneys fees and expenses, any claims pursuant to § 536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in the case of *State Board of Healing Arts v. Laster*, 06-1733 HA, currently pending before the Administrative Hearing Commission of Missouri, this agreement, and of or from the negotiation of this agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this agreement in that it survives in perpetuity even in the event that any court of law or equity deems this or any portion thereof void or unenforceable.

34. The parties acknowledge that this Agreement is the joint work product of both the Board and Laster; and that there shall be no presumptions or constructions favoring is disfavoring either party if any ambiguity or uncertainty is later determined to exist in the construction or enforcement of the terms of this Agreement.

35. In consideration of the foregoing, the parties consent to the termination of any further proceedings before the Administrative Hearing Commission within fifteen (15) days of the execution of this Agreement.

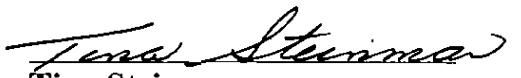


LICENSEE


Jerry L. Laster, M.D.

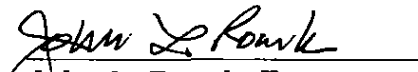
5-16-08
Date

BOARD


Tina Steinman
Executive Director, State Board
of Registration for the Healing Arts

5-22-08
Date

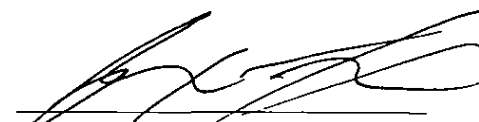
SMITH LEWIS, LLP


John L. Roark, Esq.
Smith, Lewis, LLP
Missouri Bar No. 33237

111 South Ninth Street, Suite 200
P.O. Box 918
Columbia, Missouri 65205
Telephone: (573) 443-3141
Facsimile: (573) 442-6686

Attorney for Laster

JEREMIAH W. (JAY) NIXON
Attorney General


Rex P. Fennessey
Assistant Attorney General
Missouri Bar No. 58925

7th Floor, Broadway State Office Bldg.
P.O. Box 899
Jefferson City, Missouri 65101
Telephone: (573) 751-5064
Facsimile: (573) 751-5660

Attorneys for Respondent

EFFECTIVE THIS 22 DAY OF May, 2008.